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ABSTRACT

The author describes a counseling technique which: (1) is based upon behavior theory and treats acts and thoughts as operants, and anxiety as a respondent controlled by classical conditioning; (2) entails in vivo desensitization, requiring the construction of a hierarchy of anxiety-producing situations which can be enacted; (3) uses peer- or social-models to both elicit and extinguish anxiety and aid in the development of alternative behaviors; and (4) involves a fine grain analysis of the client's thoughts and behaviors, as soon as possible after their occurrence in the treatment situation, to aid in the development of alternative thoughts and behaviors which interfere with anxiety. Two cases, with whom these procedures were successful, are discussed. (TL)

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The use of models in a desensitization procedure

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I would like to describe a counseling technique which I believe offers promise, that is based on social learning theory. The technique makes use of several concepts: (1) peers can be employed as powerful change agents, (2) a treatment procedure which entails a graduated exposure of this client to anxiety provoking stimuli is more likely to succeed, (3) the use of a peer-or social model - in this gradual desensitization is important because anxiety is elicited and extinguished by social means, and (4) carrying out a detailed analysis of the covert anxiety responses as they occur in thoughts allows for the construction of specific coping devices, i.e., alternative thoughts incompatible with anxiety.

Here are two cases where this technique was used.

The first case is of an 18 year old college student who was depressed because of marked avoidance of socialization. The models were student members of a campus organization ordinarily devoted to helping persons hospitalized for mental disorder. From this group, male and female volunteers were selected who described themselves as being confident in entering new social situations. From a brief questionnaire filled out by all volunteers, one male was selected to be interviewed about the

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techniques he used to facilitate socialization in new situations. A recording of this interview was played for the client and employed by the therapist as a basis for discussion. This was followed by a graded series of experiences with male models, since males were experienced as less anxiety-provoking than females. In the first step, the client and therapist observed through a one-way window while two volunteers met for the first time and conversed together for 20 minutes. An additional 20 minutes of discussion by all four persons then took place about the behaviors and feelings of participants. 10 minutes of discussion ensued after the two volunteers had been excused. The second step entailed the client meeting another volunteer and conversing for 20 minutes, while being observed by the therapist, followed by the same discussion arrangements as in step one. In the third step, the client met a new volunteer in a public place and conversed for about an hour, with discussion of the experience scheduled later in the week. Once having completed this sequence the procedure was repeated with female volunteers.

The second case is of a 39 year old woman who sought help for anxiety which prevented her from using public rest rooms, including at work. Specifically, she had developed a fear of being exposed in the Ladies Room to a woman who would vomit in her presence. The treatment entailed constructing a hierarchy of scenes which elicited this anxiety and then using a volunteer to accompany her through the scenes and, in fact, produce some of the anxiety-eliciting stimuli. For example, in the first scene,

the client and volunteer talked to one another at the mirror in the Ladies Room for 5 minutes; in the last scene, the volunteer was seated in an adjacent booth and feigned vomiting.

In both of these cases the treatment was successful. It is my guess that the successes were based on the use of the volunteers, the graduated sequences, and attending to particular thoughts that were either anxiety-producing or anxiety-inhibiting. It is in this sense that this technique is distinguished from an *in vivo* desensitization procedure as usually practiced. Here, critical thoughts are identified and the client is instructed as to which specific thoughts are responsible for his distress and what new thoughts may be acquired to counteract the growth of anxiety. For example, in the second case a review of the experience which had occurred moments before brought to light specific anxious thoughts which were elicited by a sudden noise; thoughts that were chained to an ultimate panic state. This chain was identified for the client and a discussion ensued which led to the development of a new thought which could be introducted into this chain by the client to disrupt the chain. The result was an immediate gaining of control as the experience was repeated. This reinforcement encouraged other behaviors from the client which further controlled the anxiety and eventually eliminated the problem.

While the arrangement of this kind of treatment program takes time, my experience suggests that the total time invested in counseling may be substantially reduced.

To summarize the main points in this technique:

First, this technique is based upon behavior theory which treats acts and thoughts as operants, and anxiety as a respondent controlled by classical conditioning.

Second, the procedure entails *in vivo* desensitization, requiring the construction of a hierarchy of anxiety-producing situations which can be enacted.

Third, models are used within this sequence to both elicit and extinguish anxiety and aid in the development of alternative behaviors.

And fourth, a fine grain analysis is made of the client's thoughts and behaviors as soon as possible after their occurrence to and in the development of alternative thoughts and behaviors which interfere with anxiety.